Alcohol Screening and Brief Intervention in the Medical Setting

Alcohol use and abuse is a major preventable public health problem, contributing to over 100,000 deaths each year and costing society over 185 billion dollars annually.[1] Patients represent the entire spectrum of alcohol-related problems. This includes drinkers "at-risk" for injury and illness, those presenting with "harmful/problem drinking" such as the impaired driver, all the way to those with signs and symptoms of alcohol dependence.

Fortunately, we now know several truths.

- **Brief intervention does work** There is compelling evidence in the literature that screening and brief intervention (SBI) for alcohol problems does work.[2] A recent evidence-based review on SBI revealed 39 published studies including 30 randomized controlled and 9 cohort studies. A positive effect was demonstrated in 32 of these studies.[3] Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings, including general populations, primary care,[4] emergency departments [5, 6, 7,8] and inpatient trauma centers. [9]

- **The ED visit is an opportunity for intervention**[10] Patients presenting to the ED are more likely to have alcohol-related problems than those presenting to primary care. Cherpitel[11] recently compared patients presenting to an ED with those presenting to a primary care setting in the same metropolitan area. She found that ED patients were one and a half to three times more likely to report heavy drinking, consequences of drinking, alcohol dependence, or ever having treatment for an alcohol problem, than patients presenting to a primary care clinic. In addition, the ED visit offers a potential "teachable moment" due to the possible negative consequences associated with the event.[12, 13.]

- **Linking patients immediately to services has proven to be successful** As early as 1957 Chafetz[5] reported that 65% of patients with alcohol dependence who were directly referred to an alcohol clinic from the ED kept their initial appointment compared to 5.4% of the control group. Bernstein[8] found that 50% of patients with alcohol and drug dependence in Project ASSERT reported follow-up with the treatment referral. Recently, another institution using Project ASSERT[14] reported similar positive results. Of the 719 patients who received a direct referral for a specialized alcohol and drug treatment program during a one year period of time, 41% were contacted. Of these, 80% made contact with the treatment facility and 78% enrolled.

- **Physicians have been reluctant to screen because of perceived barriers: lack of education, time and resources** This resource kit was developed to make the process as easy as possible. The resource kit includes recommended screening tools, an algorithm for providing brief intervention and a template for developing referrals in your community.

SCREENING

A variety of screening tools are available. Their utility varies according to their availability, ease of administration, adverse consequences, and test characteristics. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) recommends the use of quantity and frequency (Q&F) questions as well as the CAGE questionnaire. (See Quick Reference Card) The Q&F questions can elicit whether the patient is over the recommended levels for moderate drinking and therefore "at risk" for illness and injury. The CAGE questionnaire is better for identifying dependence with 90% specificity and 76% sensitivity when used in the ED.[15] Since the CAGE was originally designed for lifetime prevalence, it may be helpful to specify "during the past 12 months."

Asking Q&F questions, then adding the CAGE questions if the responses exceed moderate levels is one way to use the screens. Another approach is to jump to the CAGE questions for patients who present intoxicated with very high ethanol levels, or when dependence is suspected. This eliminates the negative connotations and resistance that can occur when the patient is asked to quantify their drinking.

BRIEF INTERVENTION

Brief interventions are short counseling sessions that can be as short as 5 minutes.[16] They often incorporate the six elements proposed by Miller and Sanchez summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy and self-efficacy. ED DIRECT is an acronym that incorporates these concepts. For "at-risk" or "harmful" drinkers that are not dependent, goal setting within safe limits, discharge instructions and a referral to primary care is all that may be needed. For those patients who are dependent or that you are unsure of their position along the spectrum of alcohol problems, the brief intervention is a negotiation process to seek further assessment and referral to a specialized treatment program.

REFERRAL/AVAILABLE RESOURCES

Each facility must develop their own resource list for their community. Surprisingly there are often more referral sources than one would expect. Enclosed is a sample brochure and a template for developing a resource list and educational materials for your facility.

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